

# New Patient Medical Packet

Drug Allergies \_\_\_\_\_

Today's Date \_\_\_\_\_ Referring Doctor \_\_\_\_\_

Patient's Name \_\_\_\_\_ Sex \_\_\_\_\_

Last First Middle

Address \_\_\_\_\_

Street/P.O. Box City State Zip Code

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: **S M W D**

Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone# (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone# (\_\_\_\_) \_\_\_\_\_

Employer Name \_\_\_\_\_ Cell Phone# (\_\_\_\_) \_\_\_\_\_

EmailAddress \_\_\_\_\_

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Street/P.O. Box City State Zip Code

Home Phone# (\_\_\_\_) \_\_\_\_\_ Work Phone# (\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

Insurance Plan \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Group # \_\_\_\_\_ Policyholder: **Self Spouse Parent Grandparent**

Policyholder's Name \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policyholder's Employer \_\_\_\_\_

## IF NO INSURANCE, PERSON RESPONSIBLE FOR BILL

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Street/P.O. Box City State Zip Code

Home Phone# (\_\_\_\_) \_\_\_\_\_ Work Phone# (\_\_\_\_) \_\_\_\_\_

## SIGNATURE

Payment is **required** at the time services are rendered.

I request and authorize that payment of authorized Medicare/ Insurance benefits be made to the physician Vivian W. Bucay, M.D. for any services furnished to me.

I also authorize release of any medical information necessary to obtain payment of insurance benefits. I understand that I am financially responsible for any balance not covered by my insurance and that a copy of this signature is as valid as an original. **If my account becomes uncollectible, I understand that SARMA, a collection agency, will be given my account and I will be responsible for the 35% charge for the collection agency fees in addition to my overdue balance.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# INITIAL VISIT QUESTIONNAIRE

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Medication patient is allergic to (if any) \_\_\_\_\_

**PLEASE CIRCLE ALL OF THE APPROPRIATE ANSWERS. IF YES IS ANSWERED FOR FAMILY, PLEASE LIST RELATIONSHIP TO THE PATIENT OUT TO THE SIDE.**

Have you and/or any family member ever been treated for any of the following:

	<b>Patient Family</b>			<b>Patient Family</b>	
High Blood Pressure	Yes	Yes	Neurological Problems	Yes	Yes
Heart Disease	Yes	Yes	Arthritis	Yes	Yes
Kidney Disease	Yes	Yes	Diabetes	Yes	Yes
Lung Disease	Yes	Yes	Cancer	Yes	Yes
Tuberculosis	Yes	Yes	Thyroid Problems	Yes	Yes
Stomach Problems	Yes	Yes	Gynecological Problems	Yes	Yes
Bowel Problems	Yes	Yes	Prostate Problems	Yes	Yes
<b>Melanoma</b>	Yes	Yes			

Have you ever been given X-ray or Grenz ray treatments to your skin? (If yes, please list areas treated)

\_\_\_\_\_  
\_\_\_\_\_

Do you or anyone in your family have at present or have had in the past the following:

	<b>Patient Family</b>			<b>Patient Family</b>	
Asthma	Yes	Yes	Psoriasis	Yes	Yes
Hay Fever	Yes	Yes	Keloids	Yes	Yes
Hives	Yes	Yes	Eczema	Yes	Yes
Diabetes	Yes	Yes	<b>Melanoma</b>	Yes	Yes

Current medications patient is taking (if any):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



VIMAN W. BUCAY, M.D.  
General, Surgical &  
Cosmetic Dermatology

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“**HIPAA**”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from payors such as Medicare and private insurances.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this Office has the right to change its Notice of Privacy Practices from time to time and that I may contact the Office at any time at the address below to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are **NOT** required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### OFFICE USE ONLY

**I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below:**

Date:	Initials:	Reason:
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VIVIAN W. BUCAY, M.D.  
General, Surgical &  
Cosmetic Dermatology

As a courtesy, our staff will be reminding you of appointments 24 to 48 hours in advance. Please remember that it is your responsibility to keep your appointment whether or not you receive a reminder phone call. We request that you call our office and confirm your appointment if a message was left for you. Due to the increasing demand for medical appointments, a \$50.00 fee will be billed to those patients who fail to keep their appointment without calling to cancel. Cosmetic patients who fail to show up for their appointment will be billed a minimum of \$100, the actual depending on the treatment booked.

We realize that there may be unforeseen circumstances that may prevent you from keeping your appointment. Please notify our office or if you call after 5 PM or before 8 AM, dial (210) 692-3000, press 0 when you hear the message and leave a message with our 24 hour answering service if you will be unable to keep your appointment. We appreciate your confidence and value our relationship with you. Thank you for your understanding.

INITIALS \_\_\_\_\_ FINANCIAL RESPONSIBILITY: I agree to be responsible for 100% of non-covered services as determined by my insurance company. I will be responsible for any fees associated with the collection of my account including fees charged by a collection agency.

INITIALS \_\_\_\_\_ Non Sufficient Funds: I agree to full responsibility for any check returned for insufficient funds, including any and all fees and penalties associated with the transaction.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_